COMPARISON OF BENEFITS*
FOR CITY OF EUGENE
IATSE-REPRESENTED EMPLOYEES

Effective July 1, 2013

Medical/Vision/Pharmacy coverage is administered by PacificSource Health Plans
Dental coverage is administered by Moda Health (formerly ODS)
City of Eugene Employee Benefits Website: www.eugene-or.gov/employeebenefits

Benefits-IATSE	City Health Plan (PPO) In-Network Benefit	City Managed Care Plan (POS) PCP/Referred In-Network Benefit	City Hybrid Plan** (POS) PCP/Referred In-Network Benefit
Note: Benefits described below for the health plan options assume plan members receive in-network services preauthorized by their City Managed Care Plan or City Hybrid Plan PCP or through the City Health Plan PPO.			
General Information			
Payroll Deduction	Individual: $60.53 per month Two-Party: $114.87 per month Family: $160.21 per month Employees may Opt-Out of health insurance with proof of other coverage.	Individual: $43.54 per month Two-Party: $88.33 per month Family: $129.01 per month Employees may Opt-Out of health insurance with proof of other coverage.	Individual: $18.71 per month Two-Party: $37.85 per month Family: $55.30 per month Employees may Opt-Out of health insurance with proof of other coverage.
Eligible Dependents	Spouse or domestic partner. Eligible children up to age 26 as long as they are not eligible to enroll in another employer-sponsored health plan, other than a group health plan of a parent.	Spouse or domestic partner. Eligible children up to age 26.	
Benefit Levels	Preferred Provider Organization (PPO) plan, using the PacificSource Preferred PSN PPO network. Most benefit levels after the deductible are : ▪ In-Network provider: 80% of discounted rates; ▪ Non-Network provider: 50% of reasonable and customary charges.	Point of Service (POS) plan, using the PacificSource Prime PSN network. Benefits are paid at the highest level when provided or referred by your PCP and using in-network providers. Most Non-Network /Non-Referred provider benefits are 50% of reasonable and customary charges after co-pay.	Point of Service (POS) plan, using the PacificSource Prime PSN network It is necessary for you and your covered dependents to choose a Primary Care Practitioner (PCP). Benefits are paid at the highest level when provided or referred by your PCP. Most Non-Network/Non-Referred provider benefits are 50% of reasonable and customary charges after co-pay.
PacificSource Service Area	Worldwide for emergencies. Service area for the PacificSource Preferred PSN and Prime PSN Networks includes all Oregon and Idaho counties. Also Pacific, Wahkiakum, Cowlitz, Clark, Skamania and Klickitat counties in Washington state. Members living outside the PacificSource network can receive in-network benefits through the Idaho Physician's Network, the Montana InterWest Health Network or the First Health Network. See Handbook for details.		

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Choice of Physician	Any qualified physician. While in the service area, you must use a network provider or hospital to receive in-network benefits.	It is necessary for you and your covered dependents to choose a Primary Care Physician (PCP). For most services, you must use or be referred by your PCP to be paid at the highest benefit level. See Benefit Handbook for exceptions.	It is necessary for you and your covered dependents to choose a Primary Care Physician (PCP). For most services, you must use or be referred by your PCP to be paid at the highest benefit level. See Benefit Handbook for exceptions.
Calendar Year Medical and Dental Deductibles	All benefits paid after the deductible is met unless otherwise noted. Medical: $150 per person; $450 maximum per family. Dental: $50 per person; $150 maximum per family.	All benefits paid after the deductible is met unless otherwise noted. Medical: No deductible for medical coverage. Dental: $50 per person; $150 maximum per family.	All benefits paid after the deductible is met unless otherwise noted. Medical: $200 per person; $600 maximum per family. Dental: $50 per person; $150 maximum per family.
Out-of Pocket Medical Maximum	$1000 per person each calendar year in addition to the deductible for covered services. Once this limit has been met, eligible charges are covered in full for remainder of calendar year.	$1,000 per person each calendar year for covered medical expenses. Once this limit has been met, eligible charges are covered in full for remainder of calendar year.	$1,000 per person each calendar year, in addition to the deductible for covered medical expenses. Once this limit has been met, eligible charges are covered in full for remainder of calendar year.
Out-of Pocket Rx Maximum	Retail pharmacy - combined Rx and Medical Maximum (see above). Mail-order not included in out-of-pocket maximum.	Retail pharmacy - $1,300 per year. Mail-order Rx not included in out-of-pocket maximum.	Retail pharmacy - $1,300 per year. Mail-order Rx not included in out-of-pocket maximum.
Annual Dental Benefit Maximum	First calendar year of coverage: $250*. Each succeeding calendar year: $1,250*. *Does not apply to essential dental benefits for members under age 16. See the Employee Benefits Handbook for details.		
Pre-existing Conditions (Does not apply to members under age 19 or for pregnancy related conditions)			
Open enrollment	If you have been enrolled for 6 consecutive months in one of the City's health plans, you may transfer at open enrollment without any pre-existing condition limitations.		
New Eligible Employees & Dependents	For members age 19 and older, benefits are limited to $2,000 during the first 6 months for illness or injuries for which you received treatment in the 90 days before coverage began. The exclusion period will be reduced by creditable coverage under another health plan.	No pre-existing condition limitations under the City Managed Care Plan.	No pre-existing condition limitations under the City Hybrid Plan.
Claims Filing	Claim forms may be submitted by either the patient or the provider.	No claim forms needed for the City Managed Care Plan.	Claim forms may be submitted by either the patient or the provider.

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For more information contact	PacificSource Health Plans – 541.225.2650 or 888.532.5332 (medical/vision/pharmacy) Moda Health - Portland Office: 888.217.2365 (dental) Risk Services Employee Benefits Program: 541.682.8868		
This comparison of benefits summarizes the general benefits under each plan. It does not provide a full description of benefits. For further information please contact PacificSource for your medical, pharmacy or vision benefits, or Moda Health for your dental benefits.			
Medical, Vision and Pharmacy Benefits – Administered by PacificSource Health Plans			
Physician Services			
Surgery/Delivery			
Inpatient Outpatient	80% after deductible. 80% physician services, no deductible 80% facility fee, after the deductible	Covered in full. $25 co-pay for professional services if performed in a physician's office. $25 co-pay for other Outpatient Surgery Services	80% after deductible. $25 co-pay for professional services if performed in a physician's office. 80% facility fee, after the deductible
Office Visits	80% after deductible; 80% no deductible for treatment of accidental injury.	Covered in full after $25 co-pay per visit.	Covered in full after $25 co-pay per visit.
Hospital Visits	80% after deductible.	Covered in full.	80% after deductible.
Allergy Injections	80% after deductible.	Covered in full.	80% after deductible.
Hospital Services			
Semi-private Room and Board	80% after deductible. (*Subject to compliance with utilization review.)*	Paid in full after $50 co-pay per day ($250 maximum per stay).	$100 co-pay then 80% (co-pay limited to 5 days)
Emergency Care			
Within Service Area	80% after deductible for treatment of illness; 80% with no deductible for treatment of accidental injury.	$100 co-pay per visit. Co-pay waived if admitted.	Emergency room visits - $100 co-pay, no deductible. Co-pay waived if admitted.
Outside of Service Area	80% after deductible for treatment of illness; 80% with no deductible for treatment of accidental injury.	$100 co-pay per visit; waived if admitted.	Emergency room visits - $100 co-pay, no deductible. Co-pay waived if admitted.
Emergency Transportation	80% after deductible	$50 per trip; waived if admitted. Air ambulance covered when preauthorized.	80% after deductible
Outpatient Services			
CT Scans and MRI	80% after deductible for illness; 80% no deductible for treatment of accidental injury.	10% co-pay with a $75 maximum.	80% after deductible

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X-Ray, Lab Tests and Radiation Therapy	80% after deductible for illness; 80% no deductible for treatment of accidental injury.	10% co-pay with a $25 maximum.	80% after deductible
Rehabilitation (Physical Therapy)	80% after deductible if prescribed by physician.	Covered in full after $25 co-pay per session; limited to 30 sessions/yr (combined with Occupational & Speech Therapy). Must be preauthorized.	Covered in full after $25 co-pay. No deductible. Limited to 30 sessions/yr (combined with Occupational & Speech Therapy). Must be preauthorized.
Occupational and Speech Therapy	80% after deductible for certain medical conditions if prescribed by physician.	Covered in full after $25 co-pay per session; limited to 30 sessions/yr (combined with Physical Therapy). Must be preauthorized.	Covered in full after $25 co-pay per session; limited to 30 sessions/yr (combined with Physical Therapy). Must be preauthorized. No deductible
Maternity Care			
Hospital Services including Caesarean Sections and Newborn Care	Covered the same as any other medical condition; routine hospital nursery care covered from date of birth. Delivery at licensed birthing center is covered at 100% after deductible.	Covered in full for outpatient delivery. Inpatient delivery covered in full after $50 co-pay per day ($250 maximum per stay).	$100 co-pay then 80% (co-pay limited to 5 days)
Physician Hospital Services including Prenatal, Delivery and Postnatal Care of Mother & Child	80% after deductible.	Covered in full after $25 co-pay per pregnancy.	80% after deductible.
Preventive and Well-Care Services			
Periodic Physical Exams	Covered at 80% to a maximum benefit of $250; no deductible.	Covered in full.	Covered in full. No deductible
Well-Baby/Child Care	Covered at 80% during first 24 months, no deductible.	Covered in full.	Covered in full. No deductible
Immunizations	Covered at 80% for adults and children; no deductible. Children under age 2 covered under Well-Baby/Child Care.	Covered in full.	Covered in full. No deductible
Cancer Screenings and Gynecological Exams, including Colonoscopy, Mammography, Breast, Pap and Pelvic Exams	Covered at 80%, no deductible. Subject to schedule of eligibility.	Covered in full. Subject to schedule of eligibility.	Covered in full. Subject to schedule of eligibility. No deductible

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Other Medical Treatment			
Alternative Care	▪ Acupuncture: 80% after deductible. ▪ Chiropractor: 80% after deductible, limited to 52 visits a calendar year. ▪ Office visits to Licensed Naturopaths ($300 benefit max), Licensed Massage Therapists ($300 benefit max), and Registered Dietitians ($200 benefit max): 80% after deductible. Benefit maximums per calendar year as noted. No limitation on number of medically necessary visits.	Services of Licensed Chiropractors, Licensed Massage Therapists, Registered Acupuncturists & Registered Dieticians; and office visits to Licensed Naturopaths $25 co-pay per visit, up to 12 visits combined for all types of alternative care providers (limited to one consultation with registered dietician) per calendar year.	Services of Licensed Chiropractors, Licensed Massage Therapists, Registered Acupuncturists & Registered Dieticians; and office visits to Licensed Naturopath: $25 co-pay per visit, up to 12 visits combined for all types of alternative care providers (limited to one consultation with registered dietician) per calendar year. No deductible
Durable Medical Equipment	Rental covered at 80% after deductible when prescribed by a physician (up to the purchase price of rental).	Covered at 80%.	Covered at 80% after deductible
Hearing Aids	Adults: 50% of eligible expenses covered after deductible, up to a $500 maximum benefit during a 36-month period. Dependent Children: 80% of eligible expenses after deductible, up to a $4000 maximum during a 48-month period. Maximum adjusted January 1 of each year.	Adults: 50% of eligible expenses covered up to a $1000 maximum benefit during a 36-month period. Dependent Children: 80% of eligible expenses with no copay, up to a $4000 maximum during a 48-month period. Maximum adjusted January 1 of each year.	Adults: 50% of eligible expenses covered after deductible up to a $1000 maximum benefit during a 36-month period. Dependent Children: 80% of eligible expenses with no copay, up to a $4000 maximum during a 48-month period. Maximum adjusted January 1 of each year.
Hearing Analysis	80% after deductible if prescribed by a physician when medically necessary.	Routine hearing exams covered in full for children under age 18 once every 24 months when performed by PCP.	Routine hearing exams covered in full for children under age 18 once every 24 months when performed by PCP.
Home Health Care	Covered in full after deductible when provided by RN or registered physical therapist and prescribed by a physician.	Covered in full when preauthorized.	80% after deductible when preauthorized.
Hospice Care	Covered in full after deductible.	Covered in full when preauthorized. ($15,000 lifetime maximum).	80% after deductible when preauthorized. ($15,000 lifetime maximum).

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Mental Health & Chemical Dependency Services, including Alcoholism	Covered the same as any other medical condition, and may be subject to deductible, coinsurance or copay and limitations. See specific service type (for example, hospital or physician services) for coverage levels. Benefits provided in accordance with state and federal requirements.		
Podiatrist	80% after deductible.	Covered in full after $25 co-pay for non-routine foot care when preauthorized by a PCP.	Covered in full after $25 co-pay for non-routine foot care when preauthorized by a PCP.
Prosthetic Devices (Pacemaker, artificial limb, etc.)	80% after deductible for devices replacing body functions.	80% for initial device replacing body function when obtained while you are covered by this Plan and when need first arises.	80% for initial device replacing body function when obtained while you are covered by this Plan and when need first arises. After deductible
Tobacco Cessation Treatment	Eligible expenses covered up to a $500 lifetime maximum benefit for members age 15 or older participating in a tobacco cessation program, and up to two quit attempts through the Quit For Life tobacco cessation program. No deductible required.		
Pharmacy			
Prescription Drugs	Retail – Deductible applies. Pay discounted price in full at pharmacy, then submit claim form for reimbursement. Generic: $10 co-pay Preferred: 20% co-pay Non-Preferred: 25% co-pay	Retail - No claim form required: Generic: 50% co-pay Preferred: 50% co-pay Non-Preferred: $40 or 50% co-pay, whichever is greater	Retail - No claim form required: Generic: 50% co-pay Preferred: 50% co-pay Non-Preferred: $40 or 50% co-pay, whichever is greater
	Mail-order (Caremark or Wellpartner) – No deductible. No claim form required: Generic: $10 co-pay Preferred: $20 or 20% co-pay* (with a $30 cap) Non-Preferred: $25 or 25% co-pay* (with a $60 cap) * whichever is greater	Mail-order (Caremark or Wellpartner) - No claim form required: Generic: $15 co-pay Preferred: $35 co-pay Non-Preferred: $70 co-pay	Mail-order (Caremark or Wellpartner) - No claim form required: Generic: $15 co-pay Preferred: $35 co-pay Non-Preferred: $70 co-pay

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Vision			
Eye Exams	80% with no deductible once every 12 months.	Children under age 18: Covered in full after $25 co-pay once every 24 months. Adults covered at 80% with no deductible once every 12 months.	Children under age 18: Covered in full after $25 co-pay once every 24 months. Adults covered at 80% with no deductible once every 12 months.
Prescription Lenses	Lenses and frames **or** cosmetic contacts covered once every 24 months. Frames $50 Single lens $20 per lens Bifocals $30 per lens Cosmetic Contacts $70 (both lenses) $60 per lens for contacts required after cataract surgery or if vision cannot be corrected to 20/70 without such lenses. Covered once every 24 months.		
Dental* - Administered by Moda Health (formerly ODS)- * The City's dental plan utilizes participating dentists who have contracts with Moda Health. Benefit levels for non-participating dental providers are based on the prevailing fee level for covered services.			
Moda Health Service Area	The Moda Health Delta Dental Premier Network includes all counties in Oregon. Members living outside of Oregon can receive in-network benefits through Moda Health's national affiliation with Delta Dental Plans Association.		
Calendar Year Dental Deductible	$50 per person; $150 maximum per family. All benefits paid after the deductible is met unless otherwise noted.		
Annual Benefit Maximum	First calendar year of coverage: $250*. Each succeeding calendar year: $1,250*. *Essential dental benefits for members under the age of 16 will not be subject to the annual dental maximum. See the Employee Benefits Handbook for details.		
Preventive Dental Care-Exams, Bite-Wing X-Rays, Fluoride, and Routine Cleaning	100% no deductible.		
Fillings, Restorative Crowns, Denture Repairs	80% after $50 deductible.		
Initial and Replacement Dentures and Bridgework	50% after $50 deductible. Covered only if previous denture or bridgework is more than five years old, and teeth were removed while the covered person was eligible for coverage under this plan.		
Orthodontia	50% with no deductible. $2,000 lifetime maximum per covered person.		

City Hybrid Plan Additional Information

**Fixed dollar co-pays, prescription drug co-pays, and disallowed charges do not apply to the annual deductible or to the out-of-pocket maximum. Expenses applied toward the annual deductible do not apply to the out-of-pocket maximum. The City Hybrid Plan will be administered under the same terms and conditions as the City Managed Care Plan.